Active Employees Information Guide For Plan Year 2012

The new plan changes for Plan Year 2012 are as follows:

CalPERS Kaiser HMO:

- An increase of $5 in the prescription drug co-pay at retail for brand medications and 31-100 day supply mail order prescriptions will be double the co-pay of a 30-day retail prescription. There will be no change to the generic co-pay for retail or mail order.

CalPERS Blue Shield:

- An increase of $5 in the prescription drug co-pay at retail for brand medication, and 90-day mail order prescriptions will be double the co-pay of a 30-day retail prescription. There will be no change to the generic co-pay at retail or mail. The member will pay the difference between the cost of a brand medication and a generic equivalent, plus the generic co-pay when a Food and Drug Administration approved generic equivalent is available.

CalPERS Blue Shield NetValue

- Expanding service areas to include Contra Costa County, and withdrawing from Santa Barbara County.
- Adding providers in Los Angeles, Riverside, Orange and San Bernardino Counties.

CalPERS Select

- Expanding service area to include Marin County

CalPERS PERS Choice, PERSCare and PERS Select Plans

- Expanding the Value Based Site of Care program, which establishes a payment threshold for three additional elective procedures. When members receive service at an outpatient hospital rather than an ambulatory surgery center the following thresholds apply:
    1. Colonoscopy - $1,500
    2. Cataract Surgery - $2,000
    3. Arthroscopy - $6,000

PORAC:

- There are no plan changes for 2012.

Prescription Benefit Basics (CalPERS):

New Pharmacy Benefit Manager for 2012

- CalPERS has selected CVS Caremark to administer prescription benefits for PPO plans effective January 1, 2012. Members will be receiving CVS Caremark Welcome Kits and Member ID cards in the mail.
- A Maintenance Choice Program will allow members to pick up a 90-day supply of medication directly from a CVS pharmacy at a time convenient to them. Members will pay their typical mail order co-pay for a prescription on the same day and be able to talk face-to-face with a pharmacist.

- Members will be able to save money by choosing "best choice" medications (generics and preferred brands) and 90-day supplies, where appropriate, in the iBenefit personalized mailing program.

Anthem Blue Cross HMO & POS Plans:

- There are no plan changes for 2012.

Dental & Vision Plans: The City will remain with Delta Dental and SafeGuard Vision. There are no plan changes for 2012.

REMINDER! HEALTHCARE REFORM CHANGES EFFECTIVE JANUARY 2011:

- Adult children are covered up to age 26, regardless of marital or student status for medical coverage. **Although not required by the Health Reform Bill, Delta Dental and SafeGuard Vision have agreed to the City's request to match the dependent age limit of 26 for dental and vision coverage.**
- Active employees are no longer able to use their EBS Flex Card or receive pre-taxed reimbursements for over-the-counter medications unless prescribed by a physician.

YOUR BENEFITS

The City of Newport Beach is proud to provide our employees with a competitive benefits package which includes: medical, dental, vision, life, flexible spending accounts (FSAs), an employee assistance program (EAP), short and long-term disability and supplemental voluntary life insurance.

Dependents that are Eligible for Benefits

Under the CalPERS and City Blue Cross HMO and POS plans, your dependents are covered to age 26, regardless of their student status or economic dependence. Dependents over age 26 are not covered under the CalPERS medical plans. For dental and vision coverage, dependents are covered to age 26 as well.

YOUR HEALTH CARE BENEFITS

Medical

HMO (Health Maintenance Organization)

An HMO is a medical plan that requires you to receive all of your care from within a network of participating physicians, hospitals, and other health care providers. In order to be covered for benefits, or be referred to a specialist, you must access medical care through your primary care physician (PCP). To find a PCP near you, call the health plan, refer to its provider directory, or visit its website. HMOs currently offered:

- **CalPERS Blue Shield HMO**
- **CalPERS Blue Shield NetValue HMO**

- **CalPERS Kaiser Permanente HMO**
- **City Blue Cross HMO**

POS (Point-Of-Service)

A POS is a "combination" plan that gives you freedom of choice by allowing you to choose between three levels of care. You can choose to visit your PCP through the HMO (Level 1), any preferred provider organization (PPO) doctor (Level 2), or any doctor or hospital outside of the network (Level 3) each time you need care. You do not need a referral from your PCP if you go to another doctor. However, when you obtain care from your PCP, the plan typically pays more and your out-of-pocket costs are less. The following POS plan is currently offered:

- **City Blue Cross POS**

PPO (Preferred Provider Organization)

A PPO is a medical plan that lets you choose between in-network providers who offer their services at discounted rates and out-of-network providers. You may see any in- or out-of-network provider; however, it costs you less if you see an in-network provider. Also, you do not need a referral to make an appointment to see a specialist. The following PPOs are currently offered through CalPERS:

- **PERS Choice – Administered by Blue Cross**
- **PERS Select – Administered by Blue Cross**
- **PERSCare – Administered by Blue Cross**
- **PORAC (PORAC dues paying members only) – Administered by Blue Cross**

For information about services covered under the medical plan options, refer to the *Medical Plans Comparison Chart*.

Dental

DHMO (Dental Health Maintenance Organization)

When you enroll in a DHMO dental plan, you must select a dental office from the plan's provider directory. After you select your dental office, this office becomes your "primary care office" and you will go to this office for all of your dental care services. If you do not obtain dental care services from this office, you will not be covered. If your primary care office is unavailable during an emergency, call the dental plan and ask for a referral. You pay no deductible under a DHMO dental plan. And, you pay no copayment for preventive services. For most other services, you must pay a copayment or predetermined fee. There is no annual maximum dollar limit on DHMO dental benefits. The following DHMO plan is currently offered:

- **Delta HMO Dental**

PPO

A PPO dental plan allows you to choose care from in-network or out-of-network providers. When you obtain care from in-network providers, the plan pays higher benefits and your

out-of-pocket costs are lower. **In-Network**—When you receive care from an in-network dentist, you pay no deductible. Delta Dental will pay benefits based on fees that have been agreed upon by Delta Dental and its participating dentists. The costs of most routine services are 100% covered. **Out-Of-Network**—When you receive care from an out-of-network dentist, you pay a $50 deductible, with a $150 maximum per family. The plan pays benefits according to what is considered reasonable and customary (R&C) for the area. Since Delta Dental and out-of-network dentists have not agreed upon fees, the dentist may charge more and your out-of-pocket costs could be higher. The following PPO dental plan is offered:

- **Delta PPO Dental**

For information about services covered under the dental plan options, refer to the *Dental Plans Comparison Chart*.

Vision

You have the option of obtaining vision care services through the SafeGuard PPO Vision plan. SafeGuard Vision offers coverage for exams, glasses, contact lenses and related vision services through SafeGuard's network of preferred providers. SafeGuard Vision also provides limited coverage for some services received by out-of-network providers.

If you use a SafeGuard Vision in-network provider, SafeGuard covers the full cost, for you and your enrolled family members for the following:

- One vision exam every 12 months, after a $10 deductible
- Corrective lenses every 12 months
- Frames every 12 months from an approved list of covered frames up to $100 retail value
- Contact lenses, if determined medically necessary or $250 ($125 per lens) towards the cost of fitting and materials once every 12 months (in lieu of other vision materials). Non-medically necessary contact lenses used for cosmetic purposes are also covered, at a lesser benefit amount.

Refer to the *Vision Summary* chart for a list of covered services.

Flexible Spending Accounts (FSA)

FSAs enable you to set aside pre-tax dollars to cover qualified expenses that you would normally pay out of your pocket with after-tax dollars. You pay no federal income, state income, or Social Security taxes on the money that you set aside in an FSA. Therefore, your take-home pay increases.

- **Health Care Flexible Spending Account**

  When you "open" an HCFSA, you tell the City to put part of your pay into an account on a pre-tax basis. This is your tax-free money to use for eligible health care expenses for you and your family, even if you or your dependents are not enrolled in

the City's medical, dental, and/or vision plans. Eligible health care expenses are those that are not covered by other medical, dental, or vision plans. Examples include:

- Medical and dental deductibles, coinsurance, and copayments
- Medicines/Prescriptions
- Vision care—including prescription glasses, contact lenses, and laser eye surgery
- You may contribute a minimum of $260, up to a maximum of $5,000 per year.

- **Dependent Care Flexible Spending Account (DCFSA)**

The DCFSA allows you to set aside pre-tax dollars for certain eligible dependent care expenses. You may contribute a minimum of $1,000, up to a maximum of $5,000 per year to your DCFSA.

- **Please note that a Flex Card debit card is available.**

Employee Benefit Services (EBS) will provide two free cards to each employee enrolled. There is a $10.00 fee for additional and replacement cards. You will have the option to use these cards if you desire, however their usage is not required. You will still have the option to complete claim forms manually. When the Flex Card is used, the funds are pulled instantly from your FSA account without having to use cash or credit cards, filing a claim, and having to wait for the reimbursement. This does not eliminate your responsibility to keep the purchase receipt. **It is an IRS requirement that all receipts for items purchased with the Flex Card are saved. The IRS, as well as, EBS can ask for substantiation at any time, and therefore receipts will be required as proof of an eligible purchase. EBS would ask for substantiation within 30 days, but the IRS can ask for those receipts in an audit.** The cards are accepted at doctor's offices, select stores/pharmacies (listed on the enclosed document), and daycares where VISA and MasterCard are accepted. The cards are activated the first time they are used. Personal identification numbers are not required to use the card. If the cashier asks for a PIN, then the card can be run through as "credit".

- **Note:** Direct deposit is available under these programs.

Life Insurance Beneficiary

Now is a good time to update your life insurance beneficiary form. With the many changes that go on in our everyday lives, it's easy to forget to update this important information. Stop by or call HR to get a new beneficiary form for completion.

Q&As: Important information

Q: ***What should I know about the City's Opt-Out program?***

A: If you provide proof of other **group** medical insurance coverage, you may be eligible to waive coverage under the City of Newport Beach group health insurance plans and receive the taxable cafeteria allowance each payday. **Whether or not you have**

waived coverage in previous years, it is necessary for you to provide supporting documentation each Open Enrollment period.

Q: ***I chose one of the CalPERS PPO plans; do I need a referral to see a specialist?***

A: If you have elected a PPO plan (PERSCare, PERS Choice, PERS Select or PORAC), you may select any provider and make an appointment. Occasionally, your PPO provider may refer you to a specialist or for other services such as diagnostic testing. You should verify that the referral is to a PPO network provider to reduce your out-of-pocket expenses. You may have to satisfy a deductible before benefits are payable under the plan, even if you choose a network provider. After you have satisfied your deductible, the plan will pay a percentage of coinsurance and you will be responsible for the remainder. The percentage paid by the insurance will be based on whether or not your provider is a PPO network provider. Please refer to the benefit booklet for your plan for complete details.

Q: ***What happens if I acquire or lose dependents after I enroll in the City's Health Benefits Program?***

A: Employees must contact Human Resources within **60 days of an event**, such as a marriage, birth, adoption, divorce, or death to make changes to their health plans (additions or deletions). Coverage will be effective the 1st day of the month following the qualifying event. Forms must be completed and filed with the various insurance carriers to accomplish the change. If you do not complete and return these forms to Human Resources within 60 days of the qualifying event date, your dependents will not be eligible for enrollment until the next Open Enrollment period.

Q: ***What are my options regarding changes in coverage under my spouse's group plan?***

A: If you currently opt-out of the City's coverage and your spouse loses his or her coverage, due to a qualifying event (i.e. loss of job), you may enroll in one of the City's plans, but you **must** complete and return the appropriate forms to Human Resources **within 60 days** of the loss of coverage. If you are enrolled in one of the City's plans and you wish to enroll in your spouse's group plan due to a qualifying event (i.e. marriage, new coverage available) you may opt-out of the City's plan by providing valid proof of other **group** medical insurance coverage and you **must** complete and return the appropriate forms to Human Resources **within 60 days** of the date of the qualifying event or effective date of new coverage.

Q: ***I am planning on retiring. What is the City's retiree health benefit program?***

A: The City has a Medical Expense Reimbursement Program (MERP). If an employee is opting out of coverage and retires from the City, they have 120 days to elect enrollment in health, dental and/or vision coverage. You can change plans or continue the same coverage at each Open Enrollment. Failure to elect any City plan (medical,

dental or vision) within 120 days from your retirement date will render you permanently ineligible from the City Blue Cross medical plans and the dental and vision plans. You may, however, enroll in any CalPERS plan at the next Open Enrollment.

If an employee is opting out of coverage or is enrolled in a City Blue Cross plan, you can choose a CalPERS medical plan at the time of your retirement, as long as you meet the following CalPERS requirements:

- If you have between 30 and 120 days between your separation date and your retirement date, you may re-enroll within 60 days of your retirement date or during Open Enrollment.
- If you separate from City employment and do not retire within 120 days into the CalPERS retirement system, you are **not** eligible for medical coverage through CalPERS at any future date.

Employees that were eligible and elected the Hybrid option of the MERP program, will receive a monthly $400 contribution (minus the PERS mandatory employer contribution if applicable) into their MERP account whether they are enrolled in a City-sponsored plan or not.

Q: ***What is HIPAA and how does it affect me?***

A: The Health Insurance Portability & Accountability Act (HIPAA) regulations in regards to protected health information (PHI) went into effect April 2004. These regulations affect how your personal health information can be utilized and who can access it. These rules limit the City's ability to assist in your claim issues (i.e. disputes, billing, complaints, etc.). Employees must contact their insurance carriers directly for all claim issues or complete an authorization form. This form can be obtained from Human Resources.

BENEFITS CONTACT INFORMATION

	Phone Number		Web Site
PERS MEDICAL PLANS			
Blue Shield HMO & Blue Shield Net Value	Member Services: Rx: Mail Order - nextRx:	800-334-5847 800-334-5847 800-293-2202	www.blueshieldca.com www.mylifepath.com www.wellpointnextrx.com
Kaiser Permanente HMO	Member Services:	800-464-4000	www.kaiserpermanente.org
PERS Choice PPO	Member Services: Rx – CVS Caremark:	877-737-7776 800-542-0284	www.anthem.com/ca/calpers www.medco.com
PERS Select PPO	Member Services: Rx – CVS Caremark:	877-737-7776 800-542-0284	www.anthem.com/ca/calpers www.medco.com
PERSCare PPO	Member Services: Rx – CVS Caremark:	877-737-7776 800-542-0284	www.anthem.com/ca/calpers www.medco.com
PORAC PPO/Indemnity	Member Services: Rx - Express Script:	800-288-6928 800-451-6245	www.anthem.com/ca/calpers www.express-scripts.com
CITY BLUE CROSS PLAN			
Anthem Blue Cross California Care HMO & POS	HMO Services: POS Services: Rx – Express Script	800-227-3771 800-288-6921 800-451-6245	www.anthem.com/ca www.express-scripts.com
DENTAL & VISION PLANS			
SafeGuard Vision Delta HMO Dental Delta PPO Dental	Member Services: Member Services: Member Services:	800-428-8789 800-765-6003 800-422-4234	www.safeguard.net www.deltadental.com www.deltadental.com
FLEXIBLE SPENDING ACCOUNTS (FSA)			
EBS (Employee Benefit Specialists)	Member Services: Automated Voice System: Fax:	888-327-2770 800-EBS-FLEX 925-460-3929	www.ebsbenefits.com
MEDICAL EXPENSE REIMBURSEMENT PROGRAM (MERP)			
OptumHealth Financial Services	Investments/Balances:	866-898-4371	www.ohfsbenefitaccess.com